Cynthia Rogers, M.D.

CONSENT FOR RELEASE OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by:

____
Signature

____
Printed Name (Patient or Representative)   Date

____
Relationship to Patient (if other than patient)

Witness:

____
Signature

____
Printed Name (Practice Representative)   Date

Patient Registration Form

____ ____________________
First Middle Last Social Security Number

Date of Birth: ________________ Male ☐ Female ☐ Marital Status: ____________

Address:____
Street

____
City State Zip

Home Phone: ________________ Mobile Phone: ________________

Preferred Contact Method: Home / Mobile

Email Address: ____________________________________

Pharmacy: ______________________________ Pharmacy Location: __________________________

I DO / DO NOT consent to the office leaving a detailed message containing medical information at any of the phone numbers listed above. (*CIRCLE ONE*)

I DO / DO NOT consent to the office discussing my medical information with: (*CIRCLE ONE*)

Person: ________________________________Relationship to patient: _____________

Person: ________________________________Relationship to patient: ______________

Emergency Contact Information:
In case of Emergency, whom should we notify? ____
Relationship to Patient: ____________________ Phone#: __________________

Insurance Information: Do you have health insurance? **Yes ☐ No ☐**

Primary Insurance Carrier: ____

Name of Insured (Guarantor): ________________ Guarantor Date of Birth: _________________

Secondary Insurance Carrier: ____

Name of Insured (Guarantor): ________________ Guarantor Date of Birth: _________________

Patient Signature: ________________________________ **Date:** _____________

Office Financial Policy

Patient Name: _______________________________ Date of Birth: _________________

We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office.

Medicare:

We are Medicare participating providers. We will bill Medicare and Medigap carriers. You will be responsible at the time of service for payment of:

a. The annual deductibles
b. Copayments
c. Charges for cosmetic services

If you have Medicare, as well as secondary coverage with a commercial plan that is not Medigap or is an insurance company with which we have no contract, we will file a claim to your secondary/supplemental carrier. If no payment is received from your secondary/supplemental carrier within 60 days after we file a claim, you will be sent a bill and will be responsible for the balance.

Non-Medicare/Commercial Plans:

If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for all charges for all covered, medically necessary services rendered. We will bill both your primary and secondary insurance plans for contracted plans. You will be responsible at the time of service for payment of :

a. The annual deductibles
b. Copayments
c. Charges for uncovered or cosmetic services

In the event that you, as the patient, or we, as the physician, are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier.

For non-Medicare patients who have insurance coverage with an insurance carrier with which we do not have a contractual relationship, please note the following:

a. We will file both your primary and secondary insurance. If we do not receive payment from your primary carrier within 45 days of filing, you will be billed for the entire amount. Payment is due 10 days after receipt of the statement.
b. If we receive payment from the primary, we will file a claim with your secondary. If we do not receive payment from your primary carrier within 45 days of filing, you will be billed for the entire amount. Payment is due 10 days after receipt of the statement.

You signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

Patient Signature: _______________________________ Date: ________________________

Out of Network Waiver Form

Date of Service: _______________

Patient Name: ________________________________ Date of Birth: ________________

Physician Name: Cynthia Rogers, M.D.

Name of Insurance: ____

Your signature below signifies that you clearly understand that

Dr. Cynthia Rogers is NOT a member of your managed care plan. Because the doctor is NOT on your plan, the expenses for today's visit will be your responsibility. This means you will have to pay the doctor's charges in full at the end of today's visit.

Our office will file a claim to your carrier as a courtesy.

Certain types of plans will not reimburse any money if the patient requests and seeks services from a physician that is NOT part of the plan or network.

Do not sign this form unless you positively understand the consequences of your visit, the charges you will have to pay, and the fact that you may not receive any of the money back from your insurance carrier.

I understand all of the above and still want to receive services from the non-participating physician today.

Signature of Patient: ___________________________ Date: ________________________

Signature of Witness: ___________________________ Date: ________________________

Medical History Form

Patient Name: ______________________________________ Date of Birth: ______________

MEDICAL HISTORY.

Please check if you have ever had any of the following diseases or conditions?

Cardiovascular
- High blood pressure [ ]
- Pacemaker [ ]
- Defibrillator [ ]
- Irregular heartbeat [ ]
- Heart Attack [ ]
- Blood clots [ ]
- Stent [ ]
- Coronary artery disease [ ]
- Stroke [ ]

Respiratory
- Emphysema/COPD [ ]
- Asthma [ ]

Gastrointestinal/Genitourinary
- Reflux/GERD [ ]
- Kidney failure [ ]

Endocrine
- Diabetes [ ]
- Hyperthyroidism [ ]
- Hypothyroidism [ ]

Head/Eyes/Ear/Nose/Throat
- Cataracts [ ]
- Glaucoma [ ]
- Hearing Loss [ ]

Infections
- MRSA [ ]
- HIV / AIDS [ ]
- Tuberculosis [ ]
- Hepatitis: A / B / C [ ]

Cancers
- Breast [ ]
- Ovarian [ ]
- Lung [ ]
- Colon [ ]
- Prostate [ ]
- Bladder [ ]
- Other ___________________ [ ]

Psychiatric/Neurologic
- Epilepsy/seizure disorder [ ]
- Alzheimer's [ ]
- Parkinson's [ ]
- Other dementia [ ]
- Depression/anxiety [ ]

Musculoskeletal
- Rheumatoid [ ]
- Osteoarthritis [ ]
- Artificial joint [ ]

Skin
- Skin cancer [ ]
  - [ ] Basal cell carcinoma
  - [ ] Squamous cell carcinoma
  - [ ] Malignant melanoma
- Actinic keratosis [ ]
- Abnormal (dysplastic) moles [ ]
- Other ______________________ [ ]

NONE **[ ]**

SURGICAL HISTORY.

Please list any surgeries you have had:

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

MEDICATIONS.

Please list any prescription medications (or aspirin) that you are taking (including topicals):

Name

____

____

____

____

____

____

____

____

____

____

____

____

____

Are you allergic to any medications: Yes / No

If yes, please list: ____

Allergy to adhesive?	YES NO	Allergy to latex?	YES NO
Allergy to epinephrine?	YES NO	Allergy to lidocaine?	YES NO
History of MRSA?	YES NO		

SOCIAL HISTORY.

Smoking Status: FORMER SMOKER CURRENT SMOKER NEVER SMOKER

Alcohol: NONE LESS THAN 1 DRINK PER DAY 1-2 DRINKS PER DAY 3 OR MORE DRINKS PER DAY

Occupation: ____

Year-round Florida resident? YES NO If not, where else do you live? ______________

Hobbies: ____

QUALITY MEASURES.

Have you received a Pneumonia vaccination? Yes / No

Do you have a health care proxy? Yes / No

Who? ______________________________________ Phone: ________________________________

Do you have a living will? Yes / No

Have you received an Influenza vaccination? Yes / No

Are you interested in the Patient Portal? Yes / No

Height: __________ Weight: ____________

FAMILY MEDICAL HISTORY.

	Mother	Father	Brother	Sister
Cancer	[ ]	[ ]	[ ]	[ ]
Heart Disease	[ ]	[ ]	[ ]	[ ]
Diabetes	[ ]	[ ]	[ ]	[ ]
Melanoma	[ ]	[ ]	[ ]	[ ]

REVIEW OF SYSTEMS.

Please check if you are currently experiencing any of the following symptoms?

Cardiovascular
- Chest pain [ ]
- Palpitations [ ]

Respiratory
- Shortness of breath [ ]
- Cough [ ]

Gastrointestinal/Genitourinary
- Abdominal pain [ ]
- Nausea/vomiting/diarrhea [ ]
- Pain with urination [ ]

Psychiatric/neurologic
- Depression [ ]
- Anxiety [ ]
- Numbness/tingling [ ]

Head/Eyes/Ear/Nose/Throat
- Change in vision [ ]
- Ringing in ears [ ]
- Headache [ ]
- Sore throat [ ]

Musculoskeletal
- Joint pain [ ]
- Muscle pain [ ]
- Muscle weakness [ ]

Systemic
- Fever/chills/night sweats [ ]
- Unexplained weight loss [ ]

None [ ]

____

PATIENT SIGNATURE (or name of person completing this form) DATE